TABLE I *Treatment of gonorrhoea in men and women with three alternative regimens*

Treatment regimen	No of patients attending: 2 or more reviews: Men	2 or more reviews: Women	1 review only: Men	1 review only: Women	No of treatment failures: Men	No of treatment failures: Women
Procaine penicillin 2·4 MU intramuscularly	43	20	10	6	0	0
Mezlocillin 1 MU intramuscularly	39	22	17	3	6*	0
Doxycycline by mouth 300 mg/day for 3 days	48	20	17	5	6	1

*3 probably reinfected.

One had received mezlocillin and was also culture negative on three occasions. One had received procaine penicillin and had not appeared for follow up.

The MICs for 114 of the isolates were recorded and these are summarised in Table II. These results are broadly in keeping with other workers' findings in Europe in the last five years.[4-6] The sensitivities of mezlocillin seem to justify the statement of Khan that this may prove to be a useful drug in the treatment of uncomplicated gonorrhoea relatively resistant to penicillin.[6]

As a result of these findings we shall continue to use our present treatment regime of procaine penicillin, as it has been shown to be both effective and cheap.

*R D Maw**
*T Horner**
J Barr,†
*Department of Genitourinary Medicine, and †Department of Bacteriology, Royal Victoria Hospital, Belfast.

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TABLE II *Minimum inhibitory concentrations (MICs) for 114 isolates of Neisseria gonorrhoea*

Antibiotic	Percentage of strains inhibited by concentrations (μg/ml) of: 0·007	0·015	0·06	0·12	0·25	0·5	1·0	2·0	4·0	5·0	10·0	20·0
Penicillin*			79	14	3	1	3					
Mezlocillin	57	75	90	4	6							
Doxycycline			22	16	13	27	14	2			4	

*30% of isolates had MICs of 0·015 μg/ml and at least 50% had MICs of 0·03 μg/ml. Not all isolates were tested at these lower concentrations, however, and percentages results at these concentrations are therefore not included in the table.

TO THE EDITOR, *British Journal of Venereal Diseases*

Cervical cytology figures for 1970-81

Sir,

We have recently completed a retrospective examination of all results of cervical smears from 1970-81 and related data including: age at time of smear test, current oral contraceptive practice, and past history of sexually transmitted disease. As colposcopy was only available to us in later years, we did not analyse the colposcopic follow up of the patients.

Our policy was to screen only women who had not had a smear elsewhere in the preceding year, and the test was carried out

TABLE I *Results of cervical smears taken in family planning clinics and the STD clinic 1970-81*

Year	Family planning clinic: No tested	Family planning clinic: No (%) dysplastic	Sexually transmitted disease clinic: No tested	Sexually transmitted disease clinic: No (%) dysplastic
1970	2846	5 (0·17)	204	6 (2·9)
1971	2192	4 (0·18)	140	4 (2·8)
1972	3619	12 (0·33)	118	3 (2·5)
1973	4642	10 (0·21)	217	10 (4·6)
1974	3840	7 (0·18)	189	5 (2·6)
1975	3579	9 (0·25)	217	10 (4·6)
1976	4560	17 (0·37)	233	21 (9·0)
1977	3241	14 (0·43)	196	21 (10·7)
1978	4552	37 (0·81)	235	21 (9·0)
1979	5552	47 (0·85)	256	19 (7·4)
1980	8979	68 (0·76)	386	45 (11·6)
1981	8116	97 (1·2)	436	56 (12·9)

after treatment of any genital infections. This selection of patients may introduce a bias but, as the policy was consistent over the period, the underlying trend demonstrated was of considerable interest.

A smear was classified as abnormal if it demonstrated CINI or more severe dysplasia. Table I shows the increase in prevalence of cervical dysplasia among women attending our clinic over this period, and is compared with the results for patients attending family planning clinics in Belfast over the same period. Table II shows that the mean age at the time of diagnosis of our patients who had abnormal cytology was consistently under 30 years. No useful information about contraceptive practice could be obtained, but table II also shows the percentage taking the pill.

TABLE II *Mean age and percentage using oral contraception at time of diagnosis of cervical dysplasia*

Year	Average age	% using oral contraception
1970	30	19
1971	22·3	25
1972	22	25
1973	29·4	33
1974	31	42
1975	26·1	44
1976	23·4	45
1977	25	44
1978	28·3	50
1979	27	40
1980	24·9	38
1981	23·2	40

Patients' past and current diagnoses were recorded and correlated with the prevalence of cervical dysplasia. Diagnoses investigated were syphilis, gonorrhoea, non-specific genital infection (data on chlamydial infection were not available), trichomoniasis, candidiasis, herpes genitalis, and genital warts. Only genital warts showed a statistically significant association with abnormal cytology, as shown in table III, for the years 1976-77 and 1979-81.

The dramatic increase in abnormal smear reports must be viewed with concern. There has been no change in our cytology laboratory's criteria for classification over the alloted period of time so we must assume it is a real increase. Briggs *et al* reported a similar high prevalence of abnormal cytology in America and commented that this warranted the routine screening of women attending STD clinics.[1] Although the relevance of mild dysplastic lesions in young women has not been firmly established,[2] these lesions cannot be overlooked. In view of recent reports of the association between the wart virus, cervical dysplasia,[3 4] and probably cervical carcinoma, the statistical association of infections with dysplasia was of considerable interest to us and will make us ensure that all our female patients have cervical cytology examination. Until the relevance of such a policy is determined, women with warts whose smear is initially negative should probably be recommended to have regular follow up smears for perhaps the following five years.

R D Maw
O Hanley

Genitourinary Medicine Clinic,
Royal Victoria Hospital,
Belfast.

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TABLE III *The statistical significance between cervical dysplasia and genital warts*

Year	No of patients	No with warts	No with dysplasia	No with both	Significance
1970	204	14	6	0	NS
1971	140	16	4	1	NS
1972	118	12	3	0	NS
1973	217	17	10	1	NS
1974	189	24	5	0	NS
1975	217	23	10	2	NS
1976	233	27	21	6	$p=0·0220$
1977	196	25	21	9	$p=0·0002$
1978	235	26	21	4	NS
1979	256	35	19	6	$p=0·0304$
1980	386	67	45	20	$p<0·001$
1981	436	63	56	15	$0·01>p>0·001$

NS = not significant; significance at $p=0·05$; Fisher's exact probability test used 1970-79; χ^2 test used 1980-81

Book Reviews

Quality Assurance Guidelines for STD Clinics 1982. Department of Health and Human Services, Training, Education and Consultation Section, VD Division, Centers for Disease Control, Atlanta, Georgia 30333, USA.

This new edition, again prepared by a nationally representative group of experts, offers up to date guidelines designed to be widely acceptable and so fulfill the aim of improved quality of service for STD patients in the USA.

The first part concerns itself with the structure and function of clinics, and such managerial problems as accessibility, registration, ambience, and patient flow. It then goes on to consider staffing and patient evaluation. Because of a persistently limited number of doctors to meet the growing demands, nurse practitioners have been introduced. They are modelled on the British midwife in terms of sound training, an appreciation of their limitations, and readily available specialist support. The second part provides protocols for each of the STDs. Definitions, diagnostic criteria, treatment, patient education, social support, follow up, and an evaluation of contacts are all adequately dealt with. Part three is a series of invaluable appendices covering a wide range of topics including a patient information sheet, examples of medical records, a procedure for purging files, equipment lists, pelvic inflammatory disease and the IUCD, and how to prepare for and deal with medical emergencies.

It is admitted in the foreword that some aspects of the guidelines are controversial.